GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Rhonda M. Medows, MD, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

January 25, 2010

Dear State Health Benefit Plan Retiree:

The general enrollment period to enroll in Medicare Part B coverage is here – from January 1 through March 31, 2010 for those who did not enroll when they first became eligible.

This is your last opportunity to enroll in Part B and have the State Health Benefit Plan (SHBP) pay for any late enrollment penalties on your behalf because you did not enroll when you first became eligible. Also, premiums will increase significantly on July 1, 2010 for those not enrolled in Part B.

Premiums increase for retirees and/or their spouse when either party reaches age 65 if SHBP has not received Medicare information. SHBP allows retirees to enroll in a Medicare Advantage Plan at any time during the year once SHBP receives verification of enrollment in Medicare Part B.

Please visit your local Social Security office to enroll in Medicare Part B. Once enrolled, please make a copy of your Medicare card and mail it and the enclosed permission slip to:

State Health Benefit Plan
P. O. Box 1990
Atlanta, GA 30301-1990.

You will need to complete the permission slip for each person Social Security states will have to pay a penalty. SHBP is not able to pay your late enrollment penalty unless we receive Medicare information and the permission slip(s) no later than **May 1, 2010**.

Sincerely,

State Health Benefit Plan

Enclosures

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

State Health Benefit Plan Individual's Late Enrollment Penalty (LEP) Authorization Form (Payment of the Medicare Part B Premium Surcharge) for One Person

In order for the State of Georgia, Department of Community Health, State Health Benefit Plan (SHBP) to pay the late enrollment premium surcharge portion of my Medicare Part B premium to the Centers for Medicare and Medicaid Services (CMS), on my behalf, I request that CMS send notice of the premium surcharge amount due to the State of Georgia, State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990.

I authorize CMS to furnish the State of Georgia, Department of Community Health, State Health Benefit Plan information from time to time as may be necessary to administer the premium surcharge payment arrangement.

I also understand that, although the State of Georgia, Department of Community Health, State Health Benefit Plan is paying the premium surcharge portion of my Medicare Part B premium, I am still responsible for paying the monthly Part B premium payment. I understand that CMS will continue to collect the monthly premium either through benefit withholding or, where there is no benefit, direct remittance.

I also understand that after signing and completing this form, it should be mailed to the State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990.

_____ _____

Print First and Last Name as shown on your insurance card | Date

_____ _____

Signature | Your Medicare Number (please print # legibly)

_____

(Please print the name of the SHBP retiree if you are covered as a dependent)

STATE HEALTH BENEFIT PLAN RETIREE RATES - January 1, 2010

Not Enrolled in one of the Medicare Advantage Plans

Single Coverage	CIGNA & UHC HMO	CIGNA & UHC HDHP	CIGNA & UHC HRA	CIGNA & UHC OAP
1 under 65 No Medicare	$100.20	$54.40	$62.50	$94.70
1 over 65 Full Medicare	$182.40	$177.40	$192.00	$201.30
1 over 65 No Medicare	$1,035.20	$1,030.20	$1,044.80	$1,054.10
1 with Part A Medicare	$696.60	$691.60	$706.20	$715.50
1 with Part B Medicare	$636.30	$631.30	$645.90	$655.30
1 with Medicare A & B	$297.70	$292.70	$307.30	$316.60
1 with Medicare A & D	$581.30	$576.20	$590.80	$600.20
1 with Medicare B & D	$521.00	$516.00	$530.60	$539.90
Family Coverage				
at least 1 not elig for Medicare & at least 1 w Medicare A	$796.80	$746.00	$768.70	$810.20
at least 1not elig for Medicare & at least 1 w/ Medicare B	$736.50	$685.70	$708.40	$750.00
at least 1 not elig for Medicare & at least 1w/ Medicare A & B	$397.90	$347.10	$369.80	$411.40
at least 1 not elig for Medicare & at least 1 w/ Medicare A & D	$681.50	$630.70	$653.40	$694.90
at least 1 not elig for Medicare & at least 1 w/ Medicare B & D	$621.20	$570.40	$593.10	$634.70
Family under 65	$240.00	$176.70	$191.10	$282.60
Both Full Medicare	$333.40	$323.40	$352.60	$371.30
Both elig- 1 w/ & 1 w/o Medicare	$1,186.20	$1,176.20	$1,205.40	$1,224.10
Both eligibile- w/no Medicare	$2,039.00	$2,029.00	$2,058.20	$2,077.00
at least 1not elig for Medicare and at least 1 w/ Full Medicare	$282.60	$231.80	$254.50	$296.00
at least 1not elig & at least 1 elig w/ No Medicare	$1,135.40	$1,084.60	$1,107.30	$1,148.90
1 Medicare A & 1 Full Medicare	$847.60	$837.60	$866.80	$885.50
1 Medicare A & 1 No Medicare	$1,700.40	$1,690.40	$1,719.60	$1,738.30
Both Medicare A	$1,361.80	$1,351.80	$1,381.00	$1,399.70
1 Medicare A & 1 Medicare B	$1,301.50	$1,291.50	$1,320.70	$1,339.50
1 Medicare A & 1 Medicare A & B	$962.90	$952.90	$982.10	$1,000.80
1 Medicare A & 1 Medicare A & D	$1,246.50	$1,236.50	$1,265.70	$1,284.40
1 Medicare A & 1 Medicare B & D	$1,186.20	$1,176.20	$1,205.40	$1,224.10
1 Medicare B & 1 Full Medicare	$787.30	$777.30	$806.50	$825.30
1 Medicare B & 1 No Medicare	$1,640.10	$1,630.10	$1,659.30	$1,678.10
Both Medicare B	$1,241.20	$1,231.20	$1,260.40	$1,279.20
1 Medicare B & 1 Medicare A & B	$902.60	$892.60	$921.80	$940.60
1 Medicare B & 1 Medicare A & D	$1,186.20	$1,176.20	$1,205.40	$1,224.10
1 Medicare B & 1 Medicare B & D	$1,125.90	$1,115.90	$1,145.10	$1,163.90
1 Medicare A & B & 1 Full Medicare	$448.70	$438.70	$467.90	$486.60
1 Medicare A & B & 1No Medicare	$1,301.50	$1,291.50	$1,320.70	$1,339.50
Both Medicare A & B	$564.00	$554.00	$583.20	$601.90
1 Medicare A & B & 1 Medicare A & D	$847.60	$837.60	$866.80	$885.50
1 Medicare A & B & 1 Medicare B & D	$787.30	$777.30	$806.50	$825.30
1 Medicare A & D & 1 Full Medicare	$732.30	$722.30	$751.50	$770.20
1 Medicare A & D & 1 No Medicare	$1,585.10	$1,575.10	$1,604.30	$1,623.00
Both Medicare A & D	$1,131.20	$1,121.20	$1,150.40	$1,169.10
1 Medicare A & D & 1 Medicare B & D	$1,070.90	$1,060.90	$1,090.10	$1,108.80
1 Medicare B & D & 1 Full Medicare	$672.00	$662.00	$691.20	$709.90
1 Medicare B & D & 1 No Medicare	$1,524.80	$1,514.80	$1,544.00	$1,562.80
Both Medicare B & D	$1,010.60	$1,000.60	$1,029.80	$1,048.60

UHC = United Healthcare
CIGNA = CIGNA Healthcare
MA = Medicare Advantage

HMO = Health Maintenance Organization
HDHP = High Deductible Health Plan
HRA = Health Reimbursement Arrangement

OAP = Open Access Plan

(see reverse side)

STATE HEALTH BENEFIT PLAN RETIREE RATES - January 1, 2010
Enrollment in one of the Medicare Advantage Plans or Split Eligibility

All Enrolled in Medicare Advantage Option	CIGNA & UHC MA Premium	CIGNA & UHC MA Standard
Single Coverage	59.30	19.30
Family Coverage (all in Medicare Advantage)	118.60	38.60

Family Coverage (at least 1 person in MA and at least 1 family member not in MA)	CIGNA & UHC HMO/MA Premium	CIGNA & UHC HMO/MA Standard	CIGNA & UHC HDHP/MA Premium	CIGNA & UHC HDHP/MA Standard	CIGNA & UHC HRA/MA Premium	CIGNA & UHC HRA/MA Standard	CIGNA & UHC OAP/MA Premium	CIGNA & UHC OAP/MA Standard
at least 1 not elig for Medicare & at least 1 with MA	159.50	119.50	113.70	73.70	121.80	81.80	154.00	114.00
all eligible for Medicare -at least 1 with MA & at least 1 without Medicare	1,094.40	1,054.40	1,089.40	1,049.40	1,104.00	1,064.00	1,113.40	1,073.40
all eligible for Medicare - at least 1 with MA & at least 1 with Medicare A	755.80	715.80	750.80	710.80	765.40	725.40	774.80	734.80
all eligible for Meidcare - at least 1 with MA & at least 1 with Medicare A & D	640.50	600.50	635.50	595.50	650.10	610.10	659.50	619.50

UHC = United HealthCare
CIGNA = CIGNA Healthcare
MA = Medicare Advantage
HMO = Health Maintenance Organization
HDHP = High Deductible Health Plan
HRA = Health Reimbursement Arrangement
OAP = Open Access Plan

September 10, 2009

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
State Health Benefit Plan
Retiree 2010 Change Form

Please read the Terms, Conditions and Instructions on the back of this form prior to completing the form.

Use this form only if you wish to change options and return it by May 1, 2010 along with the Medicare enrollment information to SHBP, P.O. Box 1990, Atlanta, GA 30301-1990.

I. Member Identification:

SSN: ___ ___ ___-___ ___-___ ___ ___ ___

Last Name _____ First _____ Middle Initial ____

II. Coverage Action - Change of Option for currently enrolled plan members and covered dependents:
Check the box(es) that best describes the reason for this action:

- ☐ Member enrolling in Medicare Part B for a July 1, 2010 effective date.
- ☐ Spouse enrolling in Medicare Part B for a July 1, 2010 effective date.
- ☐ Member is not enrolled in Medicare B effective July 1, 2010; changing option due to premium increase.
- ☐ Spouse is not enrolled in Medicare B effective July 1, 2010; changing option due to premium increase.
- ☐ I wish to change to single coverage effective July 1, 2010. **I UNDERSTAND THAT DEPENDENTS MAY ONLY BE ADDED IN THE FUTURE AS A RESULT OF A QUALIFYING EVENT.**
- ☐ I wish to drop my SHBP coverage. **I UNDERSTAND I WILL NO LONGER BE ELIGIBLE FOR SHBP COVERAGE AS A RETIREE.**

III. Options – Choose one of the options below (do NOT check more than one box below):

Acronyms: HRA (Health Reimbursement Arrangement), HDHP (High Deductible), HMO (Health Maintenance Organization), PPO (Preferred Provider Organization)

CIGNA
- ☐ Medicare Access Plus RX Standard (Medicare Advantage)
- ☐ Medicare Access Plus RX Premium (Medicare Advantage)
- ☐ Choice Fund (HRA)
- ☐ Open Access Plus (HDHP)
- ☐ Open Access Plus In Network (HMO)
- ☐ Open Access Plus (OAP)

UNITEDHealthCare
- ☐ Medicare Direct Standard (Medicare Advantage)
- ☐ Medicare Direct Premium(Medicare Advantage)
- ☐ Definity (HRA)
- ☐ HDHP
- ☐ Choice HMO
- ☐ OAP

IV. Medicare Information for enrollment in Part B:
PLEASE ATTACH A COPY OF YOUR OR YOUR SPOUSE'S MEDICARE CARD OR A COPY OF ACKNOWLEDGEMENT LETTER SHOWING HIC # CONFIRMING NEW ENROLLMENT IN MEDICARE PART B FOR SHBP TO ADJUST YOUR PREMIUM. THE HIC # MUST BE PROVIDED TO THE CENTER OF MEDICARE SERVICES (CMS) BEFORE ENROLLMENT IN A MEDICARE ADVANTAGE PLAN CAN BE APPROVED BY CMS FOR THE NEW ENROLLEE.

V. Attestation:
I have read and agree to abide by the terms, conditions, authorization and instructions provided on the back of this form. I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1,000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make false or fraudulent statements or representation to the State Health Benefit Plan regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature of Retiree: _____ Date: _____

TERMS, CONDITIONS, AUTHORIZATION AND INSTRUCTIONS
July 1, 2010 Retiree Age 65+ Medicare Part B Enrollment Form

General Information: This form is to be used only if you wish to change health plan options. You are not required to change options, but if you enroll in Medicare Part B and/or your new health premium changed as a result of the new Medicare Part B policy, you may change options, if desired.

Please review all State Health Benefit Plan (SHBP) communications and materials prior to completion of this form. Plan information is available on the SHBP Web site at www.dch.georgia.gov. It is essential that you carefully read all your materials, answer all the questions, and submit complete Medicare Part B enrollment information. **Failure to do so will financially impact your premiums.**

You should read this side of the form and then complete Sections I, II and III. Read the Attestation in Section V carefully, then sign and date the form. **Please submit the form to SHBP no later than May 1, 2010.** This will allow sufficient time to adjust your premium and timely notification to the appropriate retirement system, if applicable, of the new premium deduction from your check. This will also allow adequate time for you to receive your new insurance card, if applicable, by July 1, 2010.

Change of Coverage: Change in Option is limited to the annual Retiree Open Change Period, except under limited qualifying events.

Penalties for Misrepresentation: If a SHBP participant misrepresents eligibility information when applying for coverage, during a change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to termination of coverage (for the participant and his or her dependents(s) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his/her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law. In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Authorization: I have read and agree to abide by the terms, conditions, authorization and instructions provided on this form. If the premium amount is deducted from my monthly check, I hereby authorize SHBP to adjust the deduction for the coverage I have selected. I understand that the selected coverage will be effective the first of the month following the appropriate deduction. I also understand that I cannot change my coverage option until the next Retiree Option Change Period except under limited conditions. If I have selected an HMO option, I understand that, if I do not live in the service area of that HMO, I must remain in that option and I must use the HMO's pre-selected providers for medical benefits. If I have selected an HMO and the HMO ceases operations, I authorize SHBP to automatically transfer my coverage to the United HealthCare Definity (HRA) unless I make another coverage selection as allowed by the plan. I hereby certify that the above information and any supporting document(s) are true and correct. I understand that misrepresentation or falsification will subject me to penalties and possible legal action.